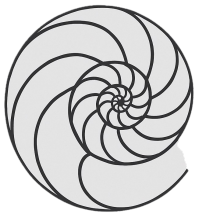

Healthcare Access and the Stability of Economic Mobility

The Healthcare Affordability Barrier: Medical Costs, Labor Participation, and Economic Security

Structural Mobility Trap Series

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Executive Summary

Healthcare affordability has emerged as a central structural obstacle to labor mobility and household economic security in the United States. High out-of-pocket costs, coverage fragility tied to employment, and the prevalence of medical debt reduce household resilience and increase the effective cost of relocation or career transition. These dynamics depress labor-force participation, disproportionately affect lower- and middle-income families, and amplify regional disparities in opportunity. Addressing healthcare-related mobility barriers requires policies that reduce financial exposure, decouple core access from brittle employment links, and integrate healthcare strategies into broader mobility and housing initiatives. Practical measuresranging from targeted cost-sharing reforms to portability of basic coverage and localized care capacity expansionscan materially improve household capacity to move, reskill, and contribute to regional productivity convergence.

1 Problem Framing

The traditional U.S. modellarge employer-based coverage, fragmented payers, and stantial cost-sharingcreates a set of intertwined risks for household mobility:

1. **Financial fragility:** Medical expenses and insurance gaps produce debt and depletion of savings that act as relocation deterrents.
2. **Employment lock-in:** Workers remain in optimal jobs to preserve health benefits, reducing reallocation toward higher-productivity opportunities.
3. **Regional capacity mismatch:** High-quality care tends to concentrate in urban centers, making relocation to growth areas more costly for households requiring regular care.
4. **Shock vulnerability:** Health shocks produce sudden income and liquidity shortfalls, with long-term impacts on mobility, education, and labor-market attachment.

These factors interact with housing costs, childcare burdens, and labor-market transitions to create a systemic mobility barrier that is both financial and operational in nature.

2 Core Drivers

1. **Employer-tied Coverage Architecture.** A large share of the population obtains comprehensive access through employers; this link creates implicit retention incentives and reduced geographic flexibility.
2. **High Out-of-Pocket Exposure.** Deductibles, copays, and non-covered services impose unpredictable costs that reduce household liquidity and savings for relocation or retraining.
3. **Medical Debt Prevalence.** Medical debts and collection practices erode creditworthiness and prevent access to housing finance and moving-related credit.
4. **Uneven Geographic Distribution of Care.** Specialty services, advanced hospitals, and networked physician groups concentrate in certain metros, increasing relocation cost for patients with chronic conditions.
5. **Administrative Frictions and Coverage Churn.** Eligibility rules, gaps between jobs, and complex enrollment processes create temporary uninsured spells that deter transitions.
6. **Labor Market Structure.** Gig, part-time, and contingent work often lacks comprehensive benefits, heightening vulnerability for workers in dynamic sectors.

3 Mechanisms and Reinforcing Loops

Employment Lock-In Loop. Employer-tied benefits create a retention incentive: workers avoid job moves to preserve coverage. Reduced mobility lowers overall labor reallocation efficiency and depresses wage growth in the long run.

Liquidity Constraint Loop. Medical expenses or anticipated health costs force households to prioritize liquidity buffers over relocation, education, or entrepreneurshipactions that would otherwise enable mobility and upward mobility.

Health-Shock Spiral. A severe health event reduces earnings capacity and increases debt, which in turn reduces household ability to relocate for recovery-supportive employment or caregiving arrangements.

Regional Care Concentration Feedback. High-quality care concentrated in frontier metros strengthens those regions ability to attract talent requiring specialized services, reinforcing geographic divergence.

4 Implications for Labor Participation and Mobility

- **Reduced voluntary job transitions**, particularly among mid-career workers with family health needs.
- **Lower geographic relocation rates** for households with care responsibilities or chronic conditions.
- **Constrained entrepreneurship** among affected cohorts due to loss of employer-backed coverage and financial risk.
- **Disproportionate effects on vulnerable groups**: lower-income, older households, and those in regions with limited care access face steeper mobility penalties.
- **Aggregate productivity impact**: a less fluid labor market reduces the speed of skills reallocation and the diffusion of best practices across firms and regions.

5 Policy and Market Responses

The objective is to reduce the healthcare-related cost of mobility while maintaining quality and sustainability.

Short-term operational measures

1. **Temporary Portability Mechanisms.** sidized bridge coverage for workers in transition (job-to-job) that preserves benefits continuity and shields against short-term uninsured spells.
2. **Targeted Cost-Sharing Caps.** Income-scaled limits on out-of-pocket medical costs for households below defined thresholds to protect mobility liquidity.
3. **Medical Debt Relief Programs.** Income-contingent or means-tested debt resolution mechanisms that restore credit access and remove relocation barriers.

Medium-term structural interventions

1. **Decoupling Essential Coverage from Employment.** Establish a baseline portable benefits systempublicly sidized, minimally comprehensivethat ensures continuity across job changes and geographic moves.
2. **Regional Care Capacity Investments.** Expand primary care, telehealth, and chronic-disease management in under-resourced regions to reduce the need for relocation for health reasons.
3. **Employer Incentives for Mobility-Friendly Benefits.** Tax or grant incentives for employers that offer portable, pro-mobility benefit packages (e.g., vesting portability, relocation allowances including care support).

Long-term system redesign

1. **Integrated MobilityHealth Policy Framework.** Embed health-access objectives into broader mobility strategies (housing, childcare, workforce programs) so that investments are coordinated and conditional on mobility outcomes.
2. **Payment and Delivery Reform.** Accelerate value-based payment models that lower per-capita cost growth and reduce unpredictable outlays that erode household liquidity.
3. **National Telehealth and Cross-State Licensing Infrastructure.** Facilitate cross-jurisdictional care delivery, credential portability for providers, and interoperable digital health records to reduce regional dependence on localized specialty centers.

6 Operational Recommendations

1. **Launch a National Transition Coverage Benefit (NTCB).** A federally backed, time-limited benefit providing comprehensive baseline coverage for workers during job transitions or relocations, with sliding sidies by income.
2. **Create a Medical Debt Clearance Initiative for Mobility-Impacted Households.** Target debt resolution for households demonstrating mobility constraints linked to medical debt, using matched federal-state financing tied to credit rehabilitation and relocation assistance.

3. **Fund Regional Primary Care Hubs.** Capital and technical assistance for mid-sized metros to develop community health hubs that provide chronic disease management and tele-specialty links to frontier centers.

4. **Implement Mobility-Linked Payment Reform Pilots.** Tie federal demonstration funding for value-based care pilots to metrics that measure impacts on household mobility and labor-market transitions.

5. **Establish Benefit Portability Standards.** Federal guidelines for portable baseline benefits, including portability of key elements (deductibles, provider networks, chronic-care authorizations).

7 Key Performance Indicators

- **Coverage Continuity Rate:** fraction of workers who maintain continuous coverage during job transitions (target baseline improvement of X% in five years).
- **Medical Debt Reduction Index:** median medical debt outstanding for bottom two income quintiles.
- **Mobility-Adjusted Financial Resilience Score:** proportion of households meeting a relocation-ready liquidity threshold (e.g., three months liquid expenditures).
- **Labor Transition Rate:** rate of voluntary job-to-job moves per 1,000 workers, stratified by caregiver and chronic-condition status.
- **Regional Care Access Index:** percentage of population within a defined travel time to primary care and common specialty services, adjusted for telehealth availability.

8 Implementation Risks and Mitigations

Risk: Fiscal cost and political feasibility. *Mitigation:* Phase-in reforms via targeted pilots and means-testing; prioritize interventions with high mobility multipliers; structure NTCB as time-limited with clear sunset clauses tied to measured outcomes.

Risk: Moral hazard and benefit gaming. *Mitigation:* Link portability benefits to employment transition documentation and use fraud-detection analytics; maintain reasonable employer responsibilities to avoid full externalization.

Risk: Provider supply constraints in targeted regions. *Mitigation:* Combine capital funding with workforce incentives (loan forgiveness, telehealth training) and cross-state licensing reforms to expand provider capacity rapidly.

Risk: Implementation complexity across states. *Mitigation:* Use federal financing with clear conditionalities and standardized metrics; deploy regional implementation partnerships to tailor local rollout.

9 Conclusion

Without healthcare portability and cost protection, housing reform, infrastructure investment, and labor mobility programs cannot fully restore opportunity flows. Healthcare is not an adjacent policy domain; it is a structural gatekeeper of mobility.

Healthcare affordability functions as a crucial gatekeeper for household mobility and, by extension, for the broader reallocation processes necessary to sustain productivity growth. Practical, staged reformsfocused on portability, cost protection, regional capacity, and payment innovationcan materially reduce the healthcare-related mobility penalty. Embedding health policy into a national mobility strategy amplifies impact: by protecting household liquidity, reducing employment lock-in, and expanding care access, policymakers can remove a key structural barrier to equitable economic dynamism.

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